Employer Name _____

Employee Name _____

ClaimLinx
10260 Alliance Road, Suite 325
Cincinnati, OH 45242
Phone (800) 858-1772 or (513) 677-6262
Fax (800) 858-1913 or (513) 677-6263
www.claimlinx.com

Primary Medical Provider Information Form

To smooth the transition of claims processing for your plan, ClaimLinx would like to contact your primary physician. This is the person you normally see for medical treatment.

Examples are: Family medicine, Internal Medicine, Pediatrician, OB/GYN, Group Practice Doctor, Allergist, etc.

Please list below any medical providers that fall into the listed categories.

1) Name _____ **Category** _____
(First Name, Last Name, Suffix)

Address _____

City/Sate/Zip _____

Phone _____ Fax _____

2) Name _____ **Category** _____
(First Name, Last Name, Suffix)

Address _____

City/Sate/Zip _____

Phone _____ Fax _____

3) Name _____ **Category** _____
(First Name, Last Name, Suffix)

Address _____

City/Sate/Zip _____

Phone _____ Fax _____

4) Name _____ **Category** _____
(First Name, Last Name, Suffix)

Address _____

City/Sate/Zip _____

Phone _____ Fax _____

****SEND COMPLETED FORM TO CLAIMLINX****
EMAIL TO ENROLLMENTS@CLAIMLINX.COM OR FAX TO (800) 858-1913